people who have no voice."

Baribeau stresses that the decision to picket a doctor's home is not taken lightly, and that picketing is not easy on the people involved: "Your convictions must be very strong to walk in front of somebody's home holding a picket sign." However, because of the conviction of his members, he says, the pickets will continue to appear, at least for the foreseeable future, in London and around the country.

The national leaders of the Campaign Life Coalition officially endorsed home picketing as a tactic at their Winnipeg convention in 1991. Plans are already in place to expand the picketing to the homes of other London doctors; Baribeau says most Canadian cities will witness similar action in the future.

From a legal standpoint, doctors can do little to stop home picketing. As long as pickets remain on public property, such as sidewalks and streets, and do not become a nuisance, police and the courts are powerless. Doctors in Cambridge and Calgary have won limited injunctions against pickets, but Fellows said they were expensive to obtain and largely ineffective because they dealt only with specific details of the protest. Consequently, placards in Cambridge cannot bear the word "kill"; however, "murder," "destroy" and "slaughter" are still legal.

The difficulty for the victims is that home picketing falls between the boundaries of two cherished rights: the right of free speech and the right to own and enjoy property. Neil Sargent, a professor of law at Carleton University in Ottawa, says this makes it difficult, if not impossible, to legislate effectively. "The question facing legislators," he says, "is when does the right to expression impinge on the right of privacy and enjoyment of one's property?"

Laws to deal with specific aspects of picketing, such as restricting the use of certain words, could be enacted, he says, but a blanket law that would withstand the inevitable court challenges is a very elusive magic pill.

All of this leaves the Fellows family in the same boat they have been in since January. The pickets resolutely maintain their daily marches and the family members, equally determined, go about their lives, ignoring the theatrics.

Fellows believes this is the only way to deal with this kind of harassment. It takes strong convictions, he says, as well as a supportive family and the tenacity to go the distance, and not all physicians are lucky enough to have all three.

He remains confident that he is doing the right thing. "I think women are sick and tired of being second-class citizens," he concludes. "A majority of them want choice and they will vote accordingly."■

Bombing of Toronto abortion clinic raises stakes in bitter debate

Gordon Bagley

The abortion clinic that Dr. Henry Morgentaler operated on Harbord Street in Toronto was an electronic fortress bristling with hidden cameras, burglary shock sensors and motion detectors, but the security measures were of little use last May 18.

At about 3:23 on that Monday morning, a security camera filmed two shadowy characters approaching the clinic's back door. The visitors, heavily disguised, used a drill to bore through the door lock. They poured gasoline into the clinic, let it aerosolize, and then used a Roman candle to ignite the fumes. In the resulting explosion the entire front wall of the two-storey structure shuddered, buckling building supports and flinging glass, bricks and other debris into the street. Fortunately, no one was injured — the street was deserted. Witnesses reported seeing a man and woman run down an alley, jump into a grey compact car and speed away.

Six months later, Toronto police seem no closer to finding the terrorists. "It appears the police have almost closed their investigation," says Morgentaler. "They had a number of leads that apparently went nowhere, and at this point I'm not very hopeful that the perpetrators will be found."

That's not the only impasse stemming from the incident. In the wake of the explosion, the Ontario government pledged to spend $420 000 to beef up security at the province's abortion facilities, and there is now a debate on how that money will be spent. The delay in spending it stems in part from a fundamental disagreement between the Ontario Attorney General's (AG) Office and the in-

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terest groups associated with Ontario's four free-standing abortion clinics, all located in Toronto.

In essence, the interest groups want the AG to place a public injunction on all free-standing abortion clinics, a move that would effectively prohibit pro-life forces from approaching and harassing people using the facilities. Anyone ignoring the injunction would be subject to arrest.

For its part, the AG's Office has been attempting to convince the interest groups to use at least some of the $420 000 to set up an operation in which the clinics, and presumably their patients, would use monitoring and surveillance techniques to gather evidence against pro-life activists, thus providing government lawyers with the evidence they need to get a private or public injunction in the courts.

While the interest groups continue to reject the idea that they should gather information that might protect them from their pro-life adversaries, the AG's Office continues to point out that a public injunction covering all abortion facilities is much tougher to obtain than a private injunction. It also says that a drawerful of evidence would be needed to convince a judge that an injunction would not infringe on antiabortionists' civil right to free expression.

Canapress photos

The Morgentaler clinic in Toronto, after the blast

Underlying the legal bickering is the apparent lack of any organized attempt by government to track the incidence of violence and harassment involving Canadian abortion clinics and their staff and patients. Indeed, while Ontario officials have been quietly gathering information since the May bombing, no central authority in Canada seems to know how often and where hospital-based or private abortion clinics have become the focus of antiabortion fanatics.

In fact, anyone trying to get any idea about the scope of the problem facing Canada's 12 private abortion clinics has to phone the National Abortion Federation (NAF) in Washington, DC; even then, the Canadian statistics are buried among US data. Since 1977 the NAF, which represents about 300 private abortion clinics, has kept records of reported incidents of violence and disruptions against abortion providers. An NAF spokesperson, who requested anonymity, says recorded acts against North American clinics have increased dramatically during the past 3 years. This followed a lull after the last peak, in 1984, when there were 18 cases involving bombings or arson. (From 1977 to 1983 there had been only eight cases.)

In North America in 1987 and 1988, there were no bombings and only 4 cases of abortion-related arson each year. In 1991, the NAF recorded 9 cases of arson; this year it has recorded 1 bomb-

ing (at the Morgentaler clinic), 10 cases of arson, 8 cases of attempted bombing/arson, 10 clinic invasions, in which people enter a clinic and attempt to take it over by locking themselves to equipment, 5 cases of assault and battery, 2 death threats and 62 cases of vandalism.

Like many in the pro-choice camp, the NAF believes that the upsurge of political activity between 1987 and 1990 by pro-life factions such as Operation Rescue, Rescue America and the Pro-Life Action Network has created an atmosphere that encourages "lone-wolf" radicals to cross the line from legal to criminal acts of protest.

That is debatable — pro-life groups steadfastly condemn acts of violence when interviewed by the media — but the suspicion among pro-choice groups exists. "Maybe [the bombing] was an isolated incident, but you never know," says Morgentaler. "I do think it's a public relations disaster for the antiabortion people. . . .

"And even if it was a 'lone-wolf' act, it's also from the radical fringe of the pro-life movement. The Toronto clinic was the target of picketing and demonstrations for years prior to the private injunction I got in 1989. These people hated the clinic."

The Toronto bombing disrupted, but did not shut down, Morgentaler's practice. "We were in business again 2 days after the blast," he says, "when Dr. [Robert] Scott [of Toronto's Scott Clinic] offered us his facilities. We've worked from there ever since on weekends and evenings, although we continue to seek new permanent quarters."

In moving to the Scott Clinic, Morgentaler took with him the 1989 private injunction that bars antiabortionists from approaching within 170 m of his clinic. The injunction, which allows no placards, contact with patients, or other disturbances or acts of trespass, is a template that the AG's Office wants all free-standing abortion clinics to seek.

For Morgentaler, and for other pro-choice advocates and groups, that's not enough. "To date, we've had two meetings with the AG's Office to persuade them to take out a public injunction, but so far they're dragging their feet on the issue. Even now, my clinic has to pay for the legal expenses involved with transferring the injunction from one place to another — that cost was supposed to be recouped through application to the $420 000 set aside last May. I hope that will happen."

Also in question are reports that some of that money would be allocated to rebuilding the Morgentaler clinic. "We heard that funds would be made available right after the incident, and we're still hoping," says Morgentaler. "Government is sympathetic, but we've received no firm promises."

And the search for a new building has not been easy, he adds. "We're having difficulty finding a property because people believe it will be the target of further violence." [In October, Morgentaler announced that he had obtained new quarters — Ed.]

Morgentaler operates clinics in St. John's, Halifax, Montreal, Toronto, Winnipeg and Edmonton; the Toronto clinic is the only one that has been successfully attacked. That fact may be significant, given the latest data from Statistics Canada. They show that while most abortions are still performed in hospitals, there's a trend, particularly in Ontario, toward the use of private clinics. In fact, 2 days after the bombing Morgentaler declared that the Harbord Street clinic had been destroyed because of its national symbolic status as the first free-standing abortion clinic in Ontario.

There may be more to the issue than symbolism, however. Last March, Statistics Canada released data that, for the first time, clearly showed that Canada is following other Western nations in a trend toward having abortions performed in private clinics instead of hospitals.

The finding is significant because of the shortage of private clinics in Canada, which has only 12 free-standing abortion clinics — Morgentaler operates half of them — plus another 12 government-funded community health centres (all in Quebec) that perform abortions.

Yet, of more than 94 000 legal abortions done in Canada during 1990, 21 443 (22.8%) took place in private clinics; almost half of those, 10 200, took place in Ontario's four private clinics, all located in Toronto.

And of those 10 200 abortions, 49.2%, or 5022 procedures, took place at the Morgentaler site on Harbord Street. In addition, data confirmed by a Morgentaler employee show that while the number of hospital-performed abortions in Ontario declined slightly, to 31 224 in 1990 from 31 644 in 1989, during the same period the Morgentaler clinic experienced a 7% increase in the number of procedures performed; in 1991, it experienced a 13% increase.

Moreover, in June 1991 the Ontario government announced that all abortions performed in the province would be covered by the Ontario Health Insurance Plan. Unlike other provinces, where women continue to pay between $200 and $400 to have abortions performed at a private clinic, all abortions in Ontario are funded by taxpayers at an average cost of $500 each.

Catherine Brown, senior consultant with the Women's Health Bureau, a branch of the Ontario Ministry of Health, says the ministry will be addressing the shift to private abortion clinics in a task

force report aimed at improving access to abortion services.

Brown says the report, which may not be made public, will not necessarily suggest that abortion services be expanded. It will propose that they be made more accessible by:

- expanding prevention and education programs in order to reduce the number of unwanted pregnancies;
- establishing networks that will provide better information for women seeking counselling or abortion, particularly on how to find doctors who will grant referrals to abortion facilities;
- improving the information kits on the laws governing abortion and its funding.

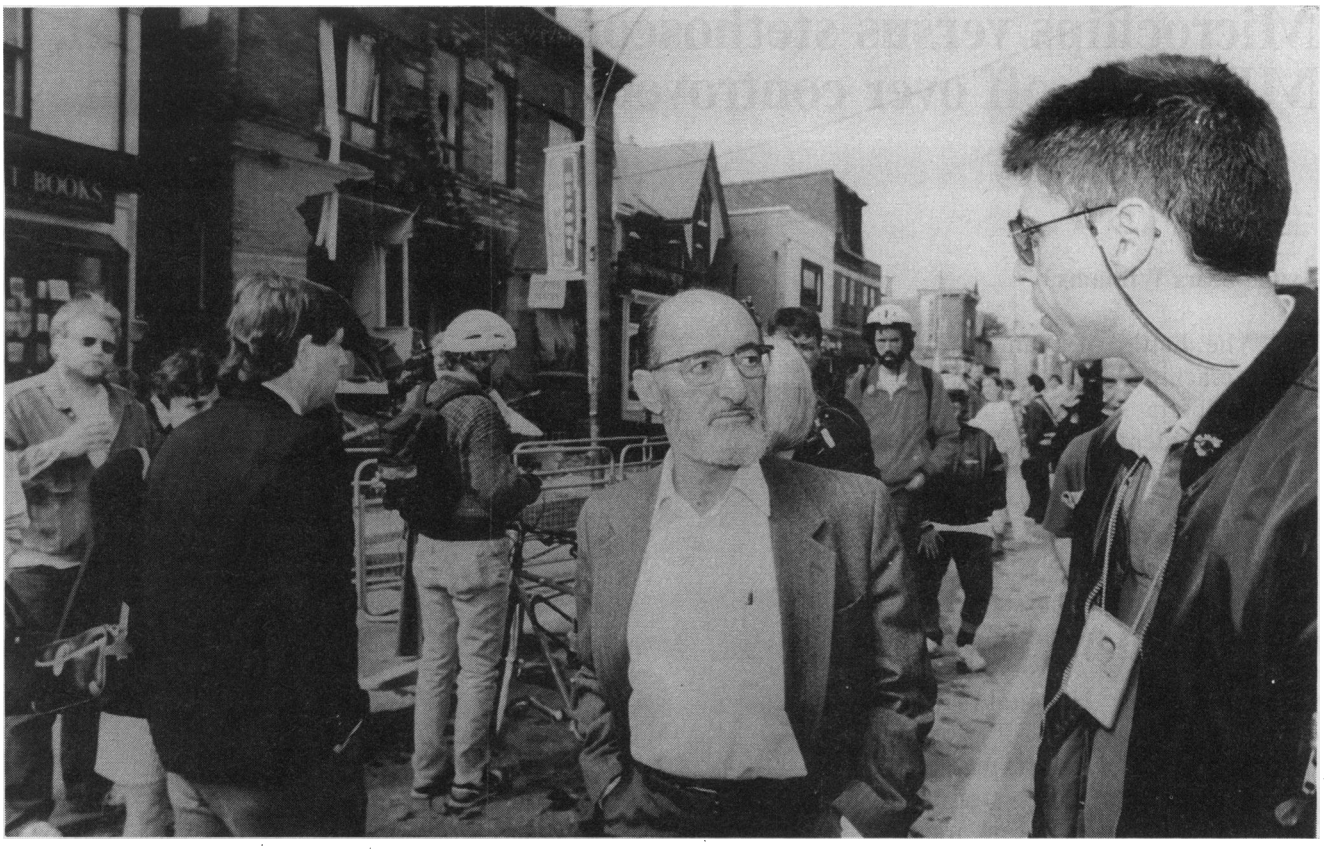
Brown says the ministry will also be working with the medical profession to improve both the training and the number of physicians who perform abortions. The shortage of doctors is a continuing problem, particularly in light of the harassment of physicians by antiabortion forces.

Although the number of abortions performed in Ontario has remained constant in recent years, Brown says there has been a geographic shift in where they are provided. For instance, doctors at hospitals in the Kitchener-Waterloo-Cambridge area performed no more than 20 abortions in 1992; 2 years ago they did 500 or more. In fact, with data showing that the province's abortions are now concentrated in Toronto and shifting to private clinics, many Toronto hospitals are seeing decreasing demand for the service.

"We don't know why, but we suspect it has to do with hospital red tape and the number of visits women are required to make before the procedure is done," says Brown. "We'll be asking hospitals if the actual demand is down or if they are capping the number they perform due to hospital costing — we need to understand that to plan for future services."

Morgentaler says the reason for the shift to clinics is obvious. "The private clinics are simply more user friendly — women don't have to come to hospital four times to get an abortion, as occurred in one recent case. The woman had to take an ultrasound, then make a second visit for a consultation with a counsellor, which was followed by a third visit for insertion of Laminaria. By the fourth visit, 24 hours later, she finally got the abortion, but only after a sleepless night and many cramps — it was like having two abortions instead of one.

"Because many Ontario hos-



Morgentaler in front of Toronto clinic after May explosion

pitals still use Laminaria and general anesthetic, which private clinics don't use, the latter can provide the service with less discomfort and quicker recovery times. That's why women come to us."

Be that as it may, the clinics are no better than the hospitals at shielding women from the pickets and slogans of the pro-life advocates who continue to besiege hospitals, doctors' homes (see previous article) and two of Toronto's three remaining free-standing abortion clinics. While the Scott Clinic has inherited the injunctive umbrella of Morgentaler's 170-m "no-go" zone, the two other clinics continue to face harassment.

The AG's Office spent the summer monitoring patterns of harassment at hospitals, clinics and providers' homes, and Attorney General Howard Hampton must soon decide if a public injunction protecting all abortion clinics is proper and feasible. If it is not, what should be done to provide legal and financial resources to abortion facilities that are seeking private restraining orders?

Rosemary Hnatiuk, a spokesperson for the AG's Office, says a decision might be made soon. To date, user groups continue to press for a public injunction that would ban antiabortionists from the area surrounding abortion facilities; Hnatiuk says they still refuse to become involved in monitoring or surveillance activities. For its part, the ministry continues to lean toward providing assistance to those seeking private injunctions.

"We'll talk to them again on the subject of surveillance," she adds. "Obviously, to get an injunction you need evidence, so the private clinics will still have to bring facts to the AG's Office. In reality, the standard of proof is more strict for the AG's Office when it seeks a public injunction, hence we would need much more information than is required to have a private injunction granted by the court."

As a result, adds Hnatiuk, providers are mistaken if they plan to avoid being drawn into monitoring and surveillance tactics by simply sitting back until a public injunction is granted.

"To date, we've been working on getting evidence together," she says. "Counsel in the ministry are calling on the hospitals and clinics for as much documented information as possible, specific instances of individual harassment have been investigated and affidavits have been sworn. We are assembling what we need to build a case.

"When we talk to the stakeholders, we'll show them the options and their chances of getting a private versus a public injunction. We expect they'll still want the public injunction, they've been very clear on that. If that holds true, the AG's Office will have to decide if it has enough evidence to proceed. If not, more discussions will be required."■

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